VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12506

## CERTIFICATE OF DEATH

Reg. Dist. No. 80

**1. PLACE OF DEATH:**

County: Carroll

City or town: Rural near Union Bridge
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): three years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Uniontown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.#1 Union Bridge Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Ira M. Albaugh

**3. (b) Social Security Number**

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Hallus Albaugh

6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): December 4, 1890

**8. AGE:** Years: 49 Months: 11 Days: 29 If less than one day: hrs. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER
12. Name: Levi A. Albaugh
13. Birthplace: Frederick Co. Md.

MOTHER
14. Maiden name: Sarah Pittinger
15. Birthplace: Frederick Co. Md.

16. Informant: Mrs Hallus Albaugh
Address: Union Bridge R#1

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Dec. 6, 1940 (month) (day) (year)

Cemetery or crematory: Linganore

Location: Unionville Md.

18. Funeral director: C. M. Waltz
Address: Winfield Md.

19. Dec 6 1940 (Date rec'd by registrar) Ernest S. Bruslert Reg. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3 1940, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1940, to December 3 1940, and that I last saw him alive on December 3 1940.

Immediate cause of death: Lobar Pneumonia — DURATION: 3 dys.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Jas. T. Thorsh M.D. M. D. or other

Address: New Windsor Md. Date signed: 1/4/40

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JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12507

Reg. Dist. No. 74

**1. PLACE OF DEATH:**
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 2 month, 2 days
Stay in this community (yrs., or mos., or days): Same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Denton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** ELBERT LOUIS ANDERSON

**3. (b) Social Security Number:** 219-07-7985

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | colored | single |

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 15, 1911

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 29 | 8 | 15 | hrs. min. |

9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Unknown

FATHER
12. Name: Louis Anderson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Hopkins
15. Birthplace: Preston, Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. St Paul Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/40 (month) (day) (year)
Cemetery or crematory: St Paul
Location: Near Denton Md.
18. Funeral director: J. Virgil Moore & Son
Address: Denton, Md.

19. Dec. 20 1940 (Date rec'd by registrar) Albert R. Swankhouser Registrar
Deputy Local

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20th. 1940, at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1940, to Dec. 20 1940, and that I last saw him alive on December 20 1940.

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | July 1940 |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Maryland Date signed: 12/20/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 4 1941
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-B)

# CERTIFICATE OF DEATH

12508

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VSA15

**1. PLACE OF DEATH:**

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 Mos.

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County None

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 100 W. 28th St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Hazel Jafuse Anderson

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife N. Wilson Anderson

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 30, 1905

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 | 2 | 9 | hrs. min. |

9. Birthplace Maryland.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name Anderson
13. Birthplace Maryland

MOTHER
14. Maiden name Minnie Wood
15. Birthplace Maryland

16. Informant Marjorie Reford
Address

17. Burial Date thereof Dec. 12, 1940
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Loudon Park

Location Balto, Md.

18. Funeral director Wm Cook

Address 1217 St Paul St

19. Dec. 10 1940 C. Harry Weld
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1940, 5:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

| | DURATION |
|---|---|
| Immediate cause of death: Acute Phenobarbital Poisoning (Suicide) | 8 hrs. |
| Due to | |
| Due to | |
| Other conditions: Huntington's Chorea | 7 yrs |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Suicide Date of 12-6-40

Where did injury occur? Baltimore (City or town) (County) Md (State)

Injured at home, farm, industry, public place (where?) Own home

Means of injury Phenobarbital Injured at work?

23. SIGNATURE J. J. Monk, Deputy Medical Examiner
M. D. or other

Address Mt. Washington Md Date signed 12/10/40

RECEIVED
JAN 4 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12509

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

**1. PLACE OF DEATH:**
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 5 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? 1 month, 5 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 916 N. Carrollton Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** SPENCER SAMUEL BAILEY

**3. (b) Social Security Number:** 218-05-4850

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 31, 1917

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 22 | 11 | 21 | hrs. min. |

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown
FATHER 12. Name: Spencer Bailey
13. Birthplace: Onancock, Va.
MOTHER 14. Maiden name: Lottie Tyler
15. Birthplace: Onancock, Va.
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/26/40 (month) (day) (year)
Cemetery or crematory: Joynes Cemetary
Location: Onancock
18. Funeral director: Benj F. Gunter
Address: Onancock Va
19. 12/22/40 (Date rec'd by registrar) 19 Albert R Goodhart Deputy Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec., 22, 1940, at 6.00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 18 1940, to Dec., 22, 1940 and that I last saw him alive on December 23, 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | Nov. 1940 |
| Due to: ---- | |
| Due to: ----- | |
| Other conditions: ---- | |

(Include pregnancy within 3 months of death)

Major findings of operations: ---- Date of op.:
Autopsy results: ----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed 12/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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DEC 24 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12510

Reg. Dist. No. 74

**1. PLACE OF DEATH:**
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 4 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Mechanicsville (Box 35)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** MARGARET MARY BANKS

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | colored | single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 17, 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 4 | 21 | ..... hrs. ..... min. |

9. Birthplace: Sandgates, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER
12. Name: Louis Banks
13. Birthplace: Maryland

MOTHER
14. Maiden name: Delia Beatt
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 16, 1940 (month) (day) (year)
Cemetery or crematory: St. Luke's
Location: Sykesville, Md.

18. Funeral director: C. Harry Weer
Address: Sykesville Md.

19. Dec. 8 1940 (Date rec'd by registrar) Albert R. Swankhamer Deputy Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 8, 1940 19..... at 11:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 19 40 to December 8 19 40 and that I last saw her alive on December 8 19 40

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1940

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 12/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIV[illegible]
JAN 4 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49.1)

## CERTIFICATE OF DEATH

12511

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County Carroll

City or town Taylorsville Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taylorsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

**3. (a) FULL NAME** Mary G. Barnes

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widow |

B (b) Name of husband ~~or wife~~ Frank M. Barnes

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 2 | 19 | hrs. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

FATHER 12. Name James Hatfield

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Margaret Dowd

MOTHER 15. Birthplace Maryland

16. Informant Bertha Hatfield

Address Taylorsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-16-1940 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Taylorsville, Md.

18. Funeral director C. H. Weer

Address Taylorsville, Md.

19. Dec 15 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/40 19 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 19 to death 19, and that I last saw h~~e~~r alive on 12/13/40 19

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of left breast | 4yrs. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Ot operations

Ot autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Laurence M.D.
M. D. or other

Address Taylorsville Md. Date signed 12/14/40

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JAN 4 - 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12512

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 3 mos., 2 days.
Hospital, institution, or street address where death occurred: Springfield State Hospital,
How long in hospital or institution? 2 yrs., 3 mos., 2 days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4314 Groveland Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** Charles Bassford.

**3. (b) Social Security Number:** #

**4. Sex:** Male.

**5. Color or race:** White.

**6.(a) Single, married, widowed, or divorced:** Married.

**6.(b) Name of husband or wife:** Maud Mason.

**6.(c) If alive, give age:** years

**7. Birth date of deceased (mo., day, yr.):** June (or July) 1873.

**8. AGE:** Years: 67. Months: 6 Days: Unk. If less than one day: hrs. min.

**9. Birthplace:** Anne Arundel Co., Md.
(Town, county, and state)

**10. Usual occupation:** Salesman.

**11. Industry or business:** Insurance.

**FATHER**
12. Name: Charles Bassford.
13. Birthplace: Maryland.

**MOTHER**
14. Maiden name: Unknown.
15. Birthplace: Unknown.

**16. Informant:** Springfield Hospital Record.
Address: Sykesville, Md.

**17.** Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 16, 1940 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto. Md

**18. Funeral director:** Wm. J. Pickus & Sons
Address: North & Pa Ave.

**19.** Dec 15 1940 C. Henry Reese
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH:** December 14, 1940 at 2.40 A. M

**21. I CERTIFY** that death occurred on the date above stated; that I attended deceased from October 12, 1938 to Dec. 13, 1940. and that I last saw h. alive on Dec 13, 1940.

Immediate cause of death: Cerebral Arteriosclerosis prior to 9-6-38. — DURATION

Due to:

Due to:

Other conditions: Myocardial Degeneration — Unk.
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

**23. SIGNATURE:** Harry F. Baer, M. D.
M. D. or other
Address: Sykesville, Md. Date signed 12-14-40

RECEIVED
DEC 23 1940
DEC 21 1940
BUREAU V. M.

12513

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 81

**1. PLACE OF DEATH:**

County: Carroll

City or town: Near Union Bridge
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): Lifetime

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Near Union Bridge Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: McKinstry Mills Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME**: Audrey Louise Boone

**3. (b) Social Security Number**: None.

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 24. 1940

**8. AGE:** Years: — Months: 2 Days: 20 If less than one day: hrs. min.

9. Birthplace: Carroll Co, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER
12. Name: Elmer C. Boone
13. Birthplace: Frederick Co Maryland

MOTHER
14. Maiden name: Myrtle Miller
15. Birthplace: Frederick Co Maryland

16. Informant: Elmer C. Boone
Address: Union Bridge, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec 14. 1940 (month) (day) (year)

Cemetery or crematory: Haughs Church Cemetery

Location: Keyman Woodsboro Road.

18. Funeral director: D. D. Hartzler & Sons
Address: Union Bridge, Md.

19. Dec. 14, 1940
(Date rec'd by registrar)
[signature] Deputy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14 1940, at 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 1940, to Dec 14 1940, and that I last saw her alive on Dec 14 1940.

Immediate cause of death: Gastro enteritis — DURATION: 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: T. N. Legg M. D. or other

Address: Union Bridge Date signed: 12-14-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

12514

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 12 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Marion Station
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war: None

**3.(a) FULL NAME:** Malcolm Charles Boston

**3.(b) Social Security Number:** None

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.): Feb., 27, 1923

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 17 | 9 | 14 | .... hrs. .... min. |

9. Birthplace: Marion Station, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: Amos Boston
13. Birthplace: Unknown, Maryland.

MOTHER
14. Maiden name: Dora Milburn
15. Birthplace: Shelltown, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Dec. 17, 1940 (month) (day) (year)

Cemetery or crematory: St. Luke's

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. 12/13/40 19.... (Date rec'd by registrar) Albert R Swankhaus Registrar
Deputy Local

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13, 1940, at 11.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1940, to Dec., 13, 1940 and that I last saw him alive on December 13 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1940

Due to: ---

Due to: ....

Other conditions: ....
(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op. ....

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Md. Date signed: 12/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BUREAU V.S.

DEC 26 1940
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-0

## CERTIFICATE OF DEATH

12515

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

**1. PLACE OF DEATH:**

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
148 W. Main Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Union Bridge Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Legal Tipple
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME**
Catherine LaRue Brand (Brooks)

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Single |

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1919

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 8 | 23 | hrs. min. |

9. Birthplace Union Bridge Carroll Co. Md.
(Town, county, and state)

10. Usual occupation House maid.

11. Industry or business Domestic Service

FATHER 12. Name Samuel Carson Brand

13. Birthplace Montgomery

MOTHER 14. Maiden name Helen Graham

15. Birthplace Montgomery

16. Informant Samuel Carson Brand

Address Union Bridge Md

17. Burial Date thereof Dec. 8-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Joy Cemetery

Location near Uniontown Md.

18. Funeral director M. L. Bartgis & Sons

Address Union Bridge Md.

19. 12/7 19 40 [signature] Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1940, at 12 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —, and that I last saw h— alive on — 19 —.

Immediate cause of death Not definitely determined, probably Acute Cardiac Dilatation — DURATION

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE J. Thomas Deputy Medical Examiner
M. D. or other

Address New Windsor Md. Date signed 12/5/40

RECEIVED
DEC 13 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12516

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 months, 1 day
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? Same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 Winters Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** RIDGELY SIDNEY COATES

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 3, 1920

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 20 | 10 | 3 | hrs. min. |

9. Birthplace: Catonsville, Maryland
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: Unknown

FATHER
12. Name: Ridgely Coates
13. Birthplace: Howard Co., Ellicott City, Md.

MOTHER
14. Maiden name: Edna Savoy
15. Birthplace: Catonsville, Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 9-40 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto. Md.

18. Funeral director: Mrs Frances A. Hemsley
Address: 518 W. Biddle St.

19. December 6 19 40 (Date rec'd by registrar) Albert R. Swanhaus Deputy Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 6 19 40, at 12:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 19 39, to Dec. 6 19 40
and that I last saw him alive on December 6 19 40

Immediate cause of death: Pulmonary Tuberculosis — DURATION: July 1939

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
Superintendent (M. D. or other)
Address: Henryton, Maryland Date signed: 12/6/40

RECEIVED
JAN 4 1941
BUREAU V. S.

12517

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 6 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 1 month, 6 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1713 Woodyear St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME**

MARGARET SARAH COLLINS

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6.(b) Name of husband or wife: Leon Collins

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): September 2, 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 3 | 24 | hrs. min. |

9. Birthplace: Ackenmac, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Unknown

FATHER
12. Name: John Smith
13. Birthplace: Ackenmac, Virginia

MOTHER
14. Maiden name: Bessue / Reed
15. Birthplace: Ackenmac, Virginia

16. Informant: Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 28 1940 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Baltimore City

18. Funeral director: Geo. G. Kelson

Address: 1303 Presstman St.

19. Dec. 26 1940 (Date rec'd by registrar) Albert R Swankhouse Deputy Local Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26th. 1940, at 2:15A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 20th. 1940, to Dec. 26th. 1940 and that I last saw her alive on December 26th. 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | Sept. 1940 |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Superintendent

Address: Henryton, Maryland Date signed: 12/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1941
BUREAU V. S.

12518

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County: Carroll.

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs., 3 mos., 13 days.

Hospital, institution, or street address where death occurred: Springfield State Hospital.

How long in hospital or institution? 8 yrs., 3 mos., 13 days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3420 Berwyn Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** Ignatius H. Craig

**3.(b) Social Security Number:** #

4. Sex: Male.

5. Color or race: White.

6.(a) Single, married, widowed, or divorced: Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 4, 1881.

8. AGE: Years 59. Months 5. Days 25. If less than one day ... hrs. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Clerk.

11. Industry or business:

FATHER
12. Name: George W. Hume Craig.
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Clementine Barton.
15. Birthplace: Baltimore, Md.

16. Informant: Springfield Hospital Record,
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/40 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Md.

18. Funeral director: C. Veron Lemmon

Address: 4611 Park Heights Ave.

19. Dec. 30 1940 (Date rec'd by registrar) C. Harry Weiss Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30, 1940, at 2:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1938, to Dec. 30, 1940, and that I last saw him alive on Dec. 29, 1940.

| Immediate cause of death | DURATION |
|---|---|
| Hypostatic Pneumonia. lobular in type C.W.G.R. | 36 hours. |
| Due to | |
| Due to Convulsive seizure Status epilepticus | 48 hrs. |
| Other conditions Traumatic Epilepsy prior to 9-16-32. attributed to a fall down stairs about 1916. | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D., M. D. or other

Address: Sykesville, Md. Date signed 12-30-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1941
BUREAU V. S.

12519

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164-e

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo. 24 da.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 mo. 24 da.

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Frederick

City or town Mouroria (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Etta May Cutsail

**3. (b) Social Security Number**

4. Sex F

5. Color or race W.

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife George Cutsail

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1879

**8. AGE:** Years 61 Months 11 Days 18 If less than one day hrs. min.

9. Birthplace Lansdale Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Julius Watkins

13. Birthplace Maryland

MOTHER 14. Maiden name Amanda Watkins

15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31 1940 (month) (day) (year)

Cemetery or crematory Bethesda

Location Brownsville

18. Funeral director J B Beall Inc

Address Damascus Md.

19. Dec 29 1940 (Date rec'd by registrar) A Harry Weer Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1940, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19

and that I last saw h alive on — 19

| Immediate cause of death | DURATION |
|---|---|
| Fracture Cervical Vertebrae | |
| Multiple Fracture of Ribs. | |
| Due to Fracture both Wrists | |
| Due to Maniac Depressive. | 4 mo |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Suicide Date of 12-29-40

Where did injury occur? Sykesville (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?) Springfield State Hospital

Means of injury Jumped out 3rd floor Window injured at work?

23. SIGNATURE Jas. T. March Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 12/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1941
BUREAU V. E.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12520

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hours

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? Same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, (If outside city or town limits, write RURAL and give nearest town)

Street No. 2133 Pennsylvania Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** UDELL IDA DAVIS

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | colored | single |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1921

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 5 | 25 | hrs. min. |

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: Unknown

FATHER
12. Name: Wm. Davis
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Ida Brinkley
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-13-1940 (month) (day) (year)

Cemetery or crematory: Mt Auburn Cemetery

Location: Balto Md

18. Funeral director: George T. A. Gibson Sr

Address: 1735 Druid Hill Ave

19. December 9 1940 (Date rec'd by registrar) Albert R Swankham Deputy Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 9 1940, at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9 1940, to Dec. 9 1940 and that I last saw her alive on December 9 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Nov. 1939

Due to:

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Superintendent

Address: Henryton, Maryland Date signed: 12/9/40

RECEIVED
JAN 4 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12521

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 12 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 10 months, 12 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3429 Paton St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** WOODIE DAVIS

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | colored | separated |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 20, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 2 | 19 | hrs. min. |

9. Birthplace: Lexington, Kentucky (Town, county, and state)

10. Usual occupation: Stable Man

11. Industry or business: Unknown

FATHER — 12. Name: Sam Davis

FATHER — 13. Birthplace: Lexington, Kentucky

MOTHER — 14. Maiden name: America Burley

MOTHER — 15. Birthplace: Lexington, Kentucky

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Dec 9 40 (month) (day) (year)

Cemetery or crematory: City Morgue

Location: Balto. Md.

18. Funeral director: Mrs Frances Dengley

Address: 578 W. Biddle St.

19. Dec. 9 1940 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1940 at 8:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 1940 to Dec. 9 1940 and that I last saw him alive on December 9, 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | Nov. 1939 |
| Due to: | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.

Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 12/9/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1941
BUREAU V. S.

12522

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? Same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 Banner St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** CLARENCE ALFONZA DICE

**3.(b) Social Security Number:** 219-01-4993

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Separated |

6.(b) Name of husband or wife: Liza Dice
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): May 17, 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 6 | 30 | ....hrs. ....min. |

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: James Dice
13. Birthplace: Prince George's County, Md.

MOTHER
14. Maiden name: Elizabeth Dyer
15. Birthplace: Washington, D.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-20-1940 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Bladensburg Md
18. Funeral director: F. Gaudis' Sons
Address: Bladensburg, Md.

19. Dec. 16 1940 (Date rec'd by registrar)
Albert R. Swanborn Deputy Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16, 1940, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 4, 1940, to Dec. 16, 1940 and that I last saw h...im alive on December 16, 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | June 1940 |
| Due to: | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed: 12/16/4

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

# CERTIFICATE OF DEATH

12523

Reg. Dist. No. 76

**1. PLACE OF DEATH:**

County Carroll

City or town Westminster Rural Mean
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 11 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural Mean Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Clarence William Duvall

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | married |

6 (b) Name of ~~husband~~ or wife Linnie Gill

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 - 1878

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 4 | 13 | hrs. min. |

9. Birthplace Warfieldsburg Carroll Co, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Albin L. Duvall
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Margrit M. Barnes
15. Birthplace Carroll Co. Md.

16. Informant Mrs Clauna Duvall

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 14. 1940 (month) (day) (year)

Cemetery or crematory Stone Chapel Cemetery

Location Nr. Warfieldsburg Carroll Co. Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md

19. 12/12/40 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11, 1940, at 6a.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2, 1940, to Dec 11, 1940, and that I last saw him alive on Dec. 11, 1940.

| Immediate cause of death | DURATION |
|---|---|
| Coronary thrombosis | 2 hours |
| Due to Coronary arterial disease | 2 Months |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Reese Wilkens
M. D. or other

Address Westminster, md. Date signed Dec 11, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40-B) ✓

## CERTIFICATE OF DEATH

12524

Reg. Dist. No. 78

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
County Carroll
City or town Enterprise
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 88 3 14

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Enterprise Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** John Wesley Duvall

**3. (b) Social Security Number** none

**4. Sex** M

**5. Color or race** W

**6.(a) Single, married, widowed, or divorced** widowed

6 (b) Name of ~~husband~~ or wife Susan Agnes Eckard
6(c) If alive, give age years

**7. Birth date of deceased (mo., day, yr.)** Aug. 25 - 1852

**8. AGE:** Years 88 | Months 3 | Days 14 | If less than one day ___ hrs. ___ min.

9. Birthplace Enterprise Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name George Duvall
13. Birthplace Md.

MOTHER
14. Maiden name Mary Cook
15. Birthplace Md.

16. Informant Mrs Angelina Duvall
Address Enterprise Carroll Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 11. 1940 (month) (day) (year)
Cemetery or crematory Meadowbranch Cemetery
Location N. Westminster Md.

18. Funeral director A Bankard & Son
Address Westminster Md.

19. Dec 10 1940 (Date rec'd by registrar) E. M. Farver Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9th 1940, at 12.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1st 1940 to Dec 9th 1940, and that I last saw him alive on Dec. 8th 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma, Gastric | 6 months |
| Due to | |
| Due to | |
| Other conditions Chronic Intestinal Nephritis | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. C. Bixler M. D. or other
Address New Windsor Md. Date signed 12/9/40

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (124-E)

12525

# CERTIFICATE OF DEATH

Reg. Dist. No. 76

**1. PLACE OF DEATH:**
County Carroll Co
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 63 Penn. Ave.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) about 17 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 63 Penn. Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR x

**3. (a) FULL NAME** Luther Oliver Eckard

**3. (b) Social Security Number** None

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Rebecca Stonesifer Eckard
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Feb. 19 1880

**8. AGE:** Years 60 | Months 9 | Days 17 | If less than one day ____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Paper - hanger
11. Industry or business
FATHER
12. Name: Thomas Eckard
13. Birthplace: Carroll Co. Md.
MOTHER
14. Maiden name: Jane Davidson
15. Birthplace: Carroll Co. Md.
16. Informant: Mrs. Luther O. Eckard
Address: 63 Penn. Ave. Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 10 40 (month) (day) (year)
Cemetery or crematory: Baust Cemetery
Location: Near Westminster, Md.
18. Funeral director: J. E. Myers, Jr.
Address: Westminster, Md
19. 12/9 1940 [signature] (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6, 1940, at 10:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1940, to Dec 6 1940, and that I last saw him alive on Dec 6, 1940.
Immediate cause of death: Acute Cardiac Dilatation — DURATION: 2 hrs.
Due to: Chronic Myocarditis + Hypertension — 5 years.
Due to:
Other conditions: Cirrhosis of liver
(Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clifford M. Taylor M.D. or other
Address: Westminster, Md Date signed 12-8-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

# CERTIFICATE OF DEATH

12526

Reg. Dist. No. 816

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Carroll

City or town Middleburg RD.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Middleburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mrs. Margaret Agnes Eyler

**3. (b) Social Security Number** none

**4. Sex** Female

**5. Color or race** W

**6. (a) Single, married, widowed, or divorced** widow

6 (b) Name of husband or wife Isaac Eyler

6(c) If alive, give age years

**7. Birth date of deceased (mo., day, yr.)** July 21, 1859

**8. AGE:** Years 81 | Months 5 | Days 1 | If less than one day ____ hrs. ____ min.

**9. Birthplace** Frederick Co- Md.

(Town, county, and state)

**10. Usual occupation** Housework

**11. Industry or business**

**FATHER**

**12. Name** Samuel Young

**13. Birthplace** Md

**MOTHER**

**14. Maiden name** Susan

**15. Birthplace** Unknown

**16. Informant** Mervin E. Eyler

Address Middleburg Md.

**17.** Burial Date thereof Dec 24, 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Hope

Location Woodsboro, Md.

**18. Funeral director** C. D. Fuss & Son

Address Taneytown, Md.

**19.** Dec 27 1940 [illegible]

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 22 1940, at 6 A.M.

**21. I CERTIFY** that death occurred on the date above stated; that I attended deceased from Dec 16 - 1940, to Dec 22 1940, and that I last saw h ex alive on Dec 21 1940.

**Immediate cause of death** Cerebral hemorrhage — DURATION 2 days

Due to Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

**Major findings:**

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

**23. SIGNATURE** J. H. Legg

M. D. or other

Address Union Bridge Date signed 12-22-40

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12527

Reg. Dist. No. 72

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Carroll

City or town Union Mills, Westminster (If outside city or town limits, write RURAL NEAR and give town) R.D.1

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 65 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Mills Westminster Ward No. R.D.1 (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Barbara Ellen Zeiser

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife William A. Zeiser

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21 1858

8. AGE: Years 82 | Months 8 | Days 16 | If less than one day hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Samuel Bachman

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Leah Bachman

MOTHER 15. Birthplace Maryland

16. Informant Milton A. Zeiser.

Address Westminster, Md. R.D.

17. Burial Date thereof Dec. 9. 1940 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Silver Run, Md.

18. Funeral director J. M. Little & Son.

Address Littlestown PA. Per R.A.L.

19. Dec. 7th 1940 Calvin B. Bennett, Registrar (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1940, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7 1940, to Dec. 7 1940, and that I last saw h e alive on Nov. 30 1940.

| Immediate cause of death | DURATION |
|---|---|
| Broncho-pneumonia and congestive heart failure | |
| Due to Hypertensive Heart Lesion | |
| Due to Generalized Arteriosclerosis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Milton A. Katz M.D. M. D. or other

Address Westminster, Md. Date signed Dec. 7, 1940

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JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12528

Reg. Dist. No. 74

**1. PLACE OF DEATH:**
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 11 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution? Same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bay Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** ELIZABETH FITZGERALD

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | colored | widow |

6.(b) Name of husband or wife: Ivan Fitzgerald
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): June 3, 1883

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 6 | 15 | ..... hrs. ..... min. |

9. Birthplace: Berlin, Maryland
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown
FATHER 12. Name: George Taylor
13. Birthplace: Berlin, Maryland
MOTHER 14. Maiden name: Mary Mears
15. Birthplace: Berlin, Maryland
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1940 (month) (day) (year)
Cemetery or crematory: Berlin
Location: Berlin, Md.
18. Funeral director: Warr & Son
Address: Sykesville, Md.
19. Dec. 18 1940 (Date rec'd by registrar) Albert R Swankhaus Deputy Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18th. 1940, at 2:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 1940, to Dec. 18 1940
and that I last saw her alive on December 18, 1940

| | DURATION |
|---|---|
| Immediate cause of death: Pulmonary Tuberculosis | Aug. 1940 |
| Due to: | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Superintendent Henryton, Maryland Date signed: 12/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JAN 4 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

12529

# CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insf. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 50

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Taneytown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Harry L. Dreet

**3. (b) Social Security Number:** none

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Bessie B. Dreet
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb 28, 1870
8. AGE: Years: 70 Months: 11 Days: 5 If less than one day: hrs. min.
9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Joseph W Dreet
13. Birthplace: Md
MOTHER 14. Maiden name: Ann Fox
15. Birthplace: Md
16. Informant: Bessie B. Dreet
Address: Taneytown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 6, 1940 (month) (day) (year)
Cemetery or crematory: Lutheran
Location: Taneytown, Md.
18. Funeral director: Ott Bros & Son
Address: Taneytown Md.
19. Dec. 6, 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3, 1940, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1939, to Dec. 2 1940, and that I last saw him alive on Dec. 2 1940.

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 2 yrs. |
| Due to Coronary Sclerosis | 4 yrs. |
| Due to Paralysis Agitans | 10 yrs. |
| Other conditions Decubitus Ulcers, Bedridden | 7 Mos. |
| Arteriosclerosis | 4 yrs. |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M.D.
M. D. or other
Address: Taneytown, Md. Date signed: 12/4/40

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JAN 3 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12530

Reg. Dist. No. 74

**1. PLACE OF DEATH:**
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 9 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 mos., 9 days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants, give residence of mother)
State: Maryland. County: Washington.
City or town: Hagerstown.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 913½ Hamilton Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** Phillip F. Gabler.

**3. (b) Social Security Number:** #

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male. | White | Married. |

6.(b) Name of ~~husband or~~ wife: Maybelle Smith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown.

8. AGE: Years: 71(?) Months: Unk. Days: Unk. If less than one day: hrs. min.

9. Birthplace: Buffalo, N. Y.
(Town, county, and state)

10. Usual occupation: Utilities Constructor (Retired)

11. Industry or business: Electric Line Construction.

FATHER
12. Name: Unknown.
13. Birthplace: Baden-Baden, Germany.

MOTHER
14. Maiden name: Elizabeth Shoemaker.
15. Birthplace: Unknown.

16. Informant: Springfield Hospital Record,
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 (month) 21 (day) 40 (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Maryland
18. Funeral director: C. Mentzer & Sons
Address: Hagerstown, Maryland

19. Dec. 18 1940 (Date rec'd by registrar) C. Harry Keen, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18, 1940, at 7:30 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9, 1940, to Dec. 18, 1940, and that I last saw h~~im~~ alive on Dec. 18, 1940.

Immediate cause of death: General Paresis prior to — Duration: 10-9-40.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D. (M. D. or other)
Address: Sykesville, Md. Date signed: 12-18-40.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 4 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12531

## CERTIFICATE OF DEATH

Reg. Diat. No. 74

**1. PLACE OF DEATH:**
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 9 mos., 10 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution? Same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1009 Creek Alley
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** MARIE GOTT

**3.(b) Social Security Number:** 215 05 8647

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | colored | single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 16, 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 25 | 5 | 16 | hrs. min. |

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business: Unknown
FATHER 12. Name: Harry Gott
13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Etta Frisby
15. Birthplace: Baltimore, Maryland
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 5, 1940 (month) (day) (year)
Cemetery or crematory: [illegible] Cemetery
Location: Reese, Md.
18. Funeral director: Walter B. Spriggs
Address: 139 W Hamburg St
19. Dec. 2 1940 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 2 1940, at 5:54A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 22 1939 to Dec. 2 1940
and that I last saw her alive on December 2 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | Aug. 1938 |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 12/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

## CERTIFICATE OF DEATH

12532

Reg. Dist. No. 72

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Carroll

City or town Route Westminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Silver Run

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Route - Westminster Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Silver Run

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mary Ellen Groft.

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | Widowed |

6 (b) Name of husband or wife Austin A. Groft.

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 8, 1863.

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 8 | — | ___ hrs. ___ min. |

9. Birthplace Silver Run Carroll Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Kessling -

13. Birthplace Maryland

MOTHER 14. Maiden name Not Known

15. Birthplace —

16. Informant A. F. Groft - Address Westminster Md. Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 11-1940 (month) (day) (year)

Cemetery or crematory Cemetery

Location Silver Run

18. Funeral director J. M. Little & Son

Address Littlestown Pa. Per R.A.L.

19. Dec. 9th 1940 (Date rec'd by registrar) Calvin E. Bankert Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 8 1940, at 1 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | — |
| Due to Arterio-Sclerosis | 17 yrs. |
| Due to — | |
| Other conditions — | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Rood Deputy Medical Examiner M. D. or other

Address Westminster Md. Date signed 12/8/40

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12533

Reg. Dist. No. 74

**1. PLACE OF DEATH:**
County: Carroll
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 yrs., 9 mos., 3 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 28 yrs., 9 mos., 3 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1613 East Chase
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** John Hamilton

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): November 5, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 1 | 6 | hrs. min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Hatter
11. Industry or business:
FATHER 12. Name: Frank Hamilton
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Harriet Jones
15. Birthplace: Pennsylvania
16. Informant: Springfield Hospital Record
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 16, 1940 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: Baltimore, Md.
18. Funeral director: Wm Cook
Address: 1217 St. Paul St.
19. Dec. 12 1940 (Date rec'd by registrar) C. Henry Rice Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 11, 1940, at 10:50 p. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938, to Dec. 11, 1940
and that I last saw him alive on Dec. 11, 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 5 years |
| Due to: | |
| Due to: | |
| Other conditions: Dementia Praecox prior to 2/8/12 | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D.
M. D. or other
Address: Sykesville, Md. Date signed: 12-11-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 14 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 53

# CERTIFICATE OF DEATH

12534

Reg. Dist. No. 76

**1. PLACE OF DEATH:**
County Carroll
City or town Westminster - Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 4 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Joseph F. Harris

**3. (b) Social Security Number**

4. Sex: Male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Mary Hobbs.
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): April 1, 1857

**8. AGE:** Years 83 | Months 8 | Days 27 | If less than one day ____ hrs. ____ min.

9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual occupation: Supt. of Geiser Mfg
11. Industry or business: Retired past 10 years.
FATHER
12. Name: David Harris
13. Birthplace: Md.
MOTHER
14. Maiden name: Margaret Haines
15. Birthplace: Md.
16. Informant: Mrs Jos. Stener
Address: Westminster Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof 12/28/40 (month) (day) (year)
Cemetery or crematory: St. Andrews Waynesboro Pa
Location: Waynesboro Pa
18. Funeral director: Walter Y Grove
Address: Waynesboro Pa
19. 12/28 19 40 L. Woodward (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28 1940, at 4:40 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7, 1940, to Dec 28, 1940, and that I last saw him alive on Dec 26, 1940.
Immediate cause of death: Endocarditis chronic — DURATION: 4 yrs
Due to
Due to
Other conditions: apparently cancerous area 1 in diameter 3rd digit rt. hand. — 3 yrs.
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: E. Reeslilkens, M.D. (M. D. or other)
Address: Westminster Date signed: Dec 28 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-C)

## CERTIFICATE OF DEATH

12535

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH**

County: Carroll

City or town: Near Manchester Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 3 mos 5 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Near Manchester Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Infant Virginia Hobbs

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| F M | White | Infant |

6 (b) Name of husband or wife: Infant

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 29 - 1940

8. AGE: Years | Months: 3 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Carroll Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER 12. Name: Arthur Hobbs

13. Birthplace: Md

MOTHER 14. Maiden name: Lillian Sellman

15. Birthplace: Md

16. Informant: Arthur Hobbs

Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5, 1940 (month) (day) (year)

Cemetery or crematory: Mt. View

Location: Howard Co. Md.

18. Funeral director: C. H. Beer

Address: Sykesville Md.

19. Dec. 4 1940 (Date rec'd by registrar) C. Harry Beer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 3 1940, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1940, to Dec 3 1940, and that I last saw h-- alive on Dec 3 1940.

| Immediate cause of death | DURATION |
|---|---|
| Immediate cause of death: Infection of bowel | 6 hours |
| Due to: Partial fecal matter | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. H. Barnes MD M. D. or other

Address: Sykesville Md Date signed 12/4/40

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JAN 4 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

12536

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

**1. PLACE OF DEATH:**
County Carroll
City or town near Manchester R.D. #1
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 65 years.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester, R.D. #1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Alice Rebecca Horick

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | Married |

6 (b) Name of husband ~~or wife~~ Jacob C. Horick
6(c) If alive, give age 96 years

7. Birth date of deceased (mo., day, yr.) Jan 24 1870

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 10 | 27 | hrs. min. |

9. Birthplace Manchester R.D.#1 Carrol Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Uriah Utz
13. Birthplace Manchester, Md.
MOTHER 14. Maiden name Rebecca L. Stegner
15. Birthplace Manchester Maryland
16. Informant Elma Seghrist
Address Glen Rock, Pa
17. Burial (Burial, cremation, or removal. Which?) Date thereof December 24, 1940 (month) (day) (year)
Cemetery or crematory St David's Cemetery
Location Hanover R.D.#3, York County, Pa
18. Funeral director Jacob Winkler Sons
Address Manchester Md
19. Dec. 23 1940 (Date rec'd by registrar) Mrs. W.R.S. Denner Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1940, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death Coronary Sclerosis
Dead on arrival

DURATION Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W R S Denner M. D. or other
Address Manchester Md Date signed 12/23/40

RECEIVED
JAN 4 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-20)

## CERTIFICATE OF DEATH

12537

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County CARROLL

City or town MT PLEASANT (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Westminster RD 1

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 35 YRS.

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State MARYLAND County CARROLL

City or town MT PLEASANT (If outside city or town limits, write RURAL NEAR and give town) Ward No.

Street No. Westminster RD 1 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** CHARLES EDWARD HOSFELD

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6 (b) Name of husband or wife ANNIE ESSICH HOSFELD

6(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) NOV. 11 1867

8. AGE: Years 73 | Months — | Days 28 | If less than one day ____ hrs. ____ min.

9. Birthplace CARROLL COUNTY MD. (Town, county, and state)

10. Usual occupation FARMER

11. Industry or business

FATHER 12. Name GEORGE A. HOSFELD

13. Birthplace GERMANY

MOTHER 14. Maiden name MARY MAHALEY

15. Birthplace UNKNOWN

16. Informant ANNIE ESSICH HOSFELD

Address MT PLEASANT

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof DEC. 7, 1940 (month) (day) (year)

Cemetery or crematory KRIDERS CEM.

Location NR. WESTMINSTER

18. Funeral director H. BANKARD — SON

Address WESTMINSTER, MD.

19. 12/6 (Date rec'd by registrar) 19 40 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1940, at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 1940, to Dec 4 1940, and that I last saw him alive on Dec 4 1940.

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | |
| Due to Hypertension | |
| Due to Enteris Sclerosis | |
| Other conditions — | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Lemmon Speicher M. D. or other

Address Westminster RD 1 Date signed Dec 6 1940

JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

## CERTIFICATE OF DEATH

12538

Reg. Dist. No. 76

**1. PLACE OF DEATH:**

County Carroll Co

City or town Westminster Rural near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
County home

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Ellis H. Hyatt

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| m | W | widowed |

6 (b) Name of husband or wife Elizabeth Amelia Hyatt

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11 1855

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 9 | 9 | hrs. min. |

9. Birthplace Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation R.W. Engineer Retired

11. Industry or business

FATHER
12. Name Thomas A. Hyatt
13. Birthplace Montgomery Co. Md.

MOTHER
14. Maiden name Alcinda Moxley
15. Birthplace Montgomery Co. Md.

16. Informant Mrs Ira D. Watkins
Address Mt. Airy, Md.

17. Burial Date thereof Dec. 22. 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Westminster Cem.

Location Westminster. Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 12/21/40 H Bankard
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1940, at 3:44 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1940 to Dec 20 1940, and that I last saw him alive on Dec 18 1940,

| Immediate cause of death | DURATION |
|---|---|
| Cardio Vascular Renal Disease & Decompensation | |
| Due to Hypertrophied Prostate + Senility | |
| Due to | |
| | |
| Other conditions | |
| (Include pregnancy within 3 months of death) | |

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Floyd Speicher M. D. or other

Address Westminster, Md. Date signed Dec 20

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

JAN 6 1941
BUREAU V. S.

12539

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 15 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 month, 15 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 564 Salem Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** J. Harry Hyde

**3.(b) Social Security Number:**

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Ella V. Cummings

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 18, 1866

**8. AGE:** Years: 74 Months: 0 Days: 14 If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Railroad Engineer

11. Industry or business:

FATHER
12. Name: Jesse L. Hyde
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ella V. Barnes
15. Birthplace: Maryland

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Scott F Minnick & Son

Address: Hagerstown Md.

19. Dec. 2 1940 (Date rec'd by registrar) C. Harry Hess Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2nd 1940 at 1:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 1940 to Dec. 2 1940 and that I last saw him alive on December 1st, 1940

Immediate cause of death: Chronic myocarditis — DURATION: Unknown

Due to: arteriosclerosis

Due to:

Other conditions: Hypertension. Chronic alcoholism
(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results: Enlarged Prostate. Cardiac hypertrophy; pulm. congestion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Alan Jacobson M.D. M. D. or other

Address: Springfield State Hosp. Date signed: 12/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a)

12540

# CERTIFICATE OF DEATH

Reg. Dist. No. 76

**1. PLACE OF DEATH:**
County Carroll
City or town Rural Nr. Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 133 Liberty
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 25 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Nr. Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 133 Liberty
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

**3. (a) FULL NAME** Franklin H. Koontz

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Alberta E. Fleagle
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1866

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 4 | 14 | hrs. min. |

9. Birthplace Silver Run, Md.
(Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name Henry Koontz
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Frock
15. Birthplace Maryland

16. Informant William H. Koontz
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 30, 1940 (month) (day) (year)
Cemetery or crematory Silver Run
Location Silver Run, Md.
18. Funeral director J. Francis Reese
Address Westminster, Md.

19. [illegible] 1940 [illegible] Woodward
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1940, at 7 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1st 1940, to Dec. 27th 1940, and that I last saw him alive on Dec. 26th 1940.

Immediate cause of death Cardio-Renal-Vascular Disease — DURATION 8 yrs.
Due to Uremic Coma — 3 days
Due to
Other conditions Amputation of leg for gangrene 2 yrs. ago.
(Include pregnancy within 6 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. L. Billingslea M. D. or other
Address Westminster, Md. Date signed 12-28-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12541

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 8 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? Same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Sharpersville, Waldorf
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**

Vincent Dominick Lancaster

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | colored | single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 10, 1924

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 16 | 5 | 7 | ..... hrs. ..... min. |

9. Birthplace: Skatway, Maryland
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: Unknown

FATHER
12. Name: Dominick Lancaster
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Virginia Jones
15. Birthplace: Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-18-40 (month) (day) (year)

Cemetery or crematory: Skatway

Location: Pescataway Md

18. Funeral director: Hunt & Ryon

Address: Waldorf Md.

19. Dec. 17 1940 (Date rec'd by registrar) Albert R. Swankhouse Deputy Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 17, 1940 19 ..... at 7:00P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 9 1940, to Dec. 17 1940 and that I last saw him alive on December 17 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1938

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Superintendent

Address: Henryton, Maryland Date signed 12/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

12542

# CERTIFICATE OF DEATH

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 16 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? Same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1205 Park Avenue
(If rural, give LOCATION)

2.(c) If veteran, name war:

**3. (a) FULL NAME**: Ruth Lindsay

**3. (b) Social Security Number**:

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | colored | single |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21, 1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 17 | 4 | 25 | hrs. min. |

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: Unknown

FATHER
12. Name: Richard Lindsay
13. Birthplace: Essex, Virginia

MOTHER
14. Maiden name: Sarah Ball
15. Birthplace: Woolsey, Virginia

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/19/40 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: A A Co. Md

19. Funeral director: Mrs Geo. H Holland

Address: 1631 Howard Hill Ave

19. December 16 40 (Date rec'd by registrar) Albert R. Swankhouse Deputy Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1940, at 1:04 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1940, to December 16 1940 and that I last saw her alive on December 16 1940

Immediate cause of death: Tuberculous Empyema

Due to: Pulmonary Tuberculosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

| DURATION |
|---|
| July 23, 1940 |
| Feb. 1940 |

Major findings of operations:

Date of op.:

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Superintendent Henryton, Maryland Date signed 12/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12543

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 67-10-9

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Horatio M. Loats

**3. (b) Social Security Number:** 216-05-3846

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. H. M. Loats
6(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): Jan. 29. 1873
8. AGE: Years: 67 Months: 10 Days: 9 If less than one day: hrs. min.
9. Birthplace: Maryland (State or foreign country)
10. Usual occupation: Cigar Maker
11. Industry or business:
FATHER 12. Name: Lewis Loats
13. Birthplace: Maryland
MOTHER 14. Maiden name: Rebecca Gayle
15. Birthplace: Penna.
16. Informant: Mrs. H. M. Loats
Address: Manchester Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof 12-11-40 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Wink's Sons
Address: Manchester Md
19. Dec. 10 1940 Mrs. W. R. S. Denner
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9 1940, at 8A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1940, to Dec 9 1940, and that I last saw h[illegible] alive on Dec 9 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Coronary Sclerosis | Sudden |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W R S Denner M. D. or other
Address: Manchester Md Date signed 10/17/40

RECEIVED
JAN 4 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12544

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County Carroll

City or town Sykesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one year, two days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? one year, two days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3305 Brighton St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** John William Manahan

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Divorced |

6.(b) Name of ~~husband~~ or wife Jessie M. Gerwid

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 20, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 9 | 10 | ..... hrs. ..... min. |

9. Birthplace Howard County, Md.

(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business

FATHER

12. Name Louis Manahan

13. Birthplace Maryland

MOTHER

14. Maiden name Annie Williams

15. Birthplace Maryland

16. Informant Springfield Hospital Record

Address Sykesville, Md.

17. Burial Date thereof Jan. 1, 1941

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Lion

Location Howard Co, Md.

18. Funeral director O. H. Baer

Address Sykesville Md.

19. Dec 30 1940 O. Harry Baer

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1940 at 12:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22, 1940, to Dec. 30, 1940

and that I last saw him alive on Dec. 30, 1940

| Immediate cause of death | DURATION |
|---|---|
| Acute Cardiac Dilatation | 3 hours |
| Due to Exhaustion | |
| Due to Manic-Depressive Psychosis, Manic Phase | 3 mos. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M. D.

M. D. or other

Address Sykesville, Md. Date signed 12-30-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JAN 4 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

12545

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Carroll
City or town Sykesville Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 3 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Sykesville
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** August F. Mielke

**3. (b) Social Security Number**

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Bertha Mielke
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Aug. 21, 1851
8. AGE: Years 89 | Months 3 | Days 27 | If less than one day ____ hrs. ____ min.
9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business
FATHER 12. Name: Carl Mielke
13. Birthplace: Germany
MOTHER 14. Maiden name: Unk.
15. Birthplace: Germany
16. Informant: George Ruch
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 21, 1940 (month) (day) (year)
Cemetery or crematory: Wards Chapel
Location: Liberty Road
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. Dec 19 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18, 1940, at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to Dec 16 1940, and that I last saw him alive on Dec 16th 1940.

| Immediate cause of death | DURATION |
|---|---|
| Chr. Myocarditis | |
| Due to Arteriosclerosis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other
Address Randalletown Date signed 12/18/40

RECEIVED
JAN 4 1941
BUREAU V. S.

12546

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48-(B) ✓

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

**1. PLACE OF DEATH:**

County: Carroll

City or town: Gamber
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 10 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Gamber Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Mollie R. Montemore

**3. (b) Social Security Number:** none

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Montemore

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): October 29, 1880

8. AGE: Years 60 | Months 1 | Days 3 | If less than one day ___ hrs. ___ min.

9. Birthplace: Tom's Brook, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William O. Goodman
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elmira Borden
15. Birthplace: Virginia

16. Informant: Mrs. A. M. Taylor

Address: Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/5/40 (month) (day) (year)

Cemetery or crematory: Providence

Location: Gamber, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 12/4 1940 (Date rec'd by registrar) [signature] Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2, 1940, at 9p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1940, to Dec. 2 1940, and that I last saw her alive on Dec. 2 1940.

Immediate cause of death: Carcinoma of uterus — DURATION: 1½ yrs

Due to ✓

Due to ✓

Other conditions: cachexia
(Include pregnancy within 3 months of death)

Major findings:

Of operations ✓

Of autopsy ✓

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ✓ Date of ✓

Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓

Means of Injury ✓ Injured at work? ✓

23. SIGNATURE: James G. Safell M. D. or other

Address: Reisterstown, Md. Date signed: 12/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 20 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12547

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs 6 mo 23 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 11 yrs 6 mo 23 da

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants, give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1902 West Fayette St

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME** Catherine Mulroy

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | widowed |

6.(b) Name of husband or wife (Unknown) Mulroy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 6, 1883.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 9 | 3 | ..... hrs. ..... min. |

9. Birthplace: Ireland.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Michael Dolan

13. Birthplace: Ireland.

MOTHER 14. Maiden name (Unknown) Dunn

15. Birthplace: Ireland

16. Informant: Hospital Records

Address: Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-12-40 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Old Frederick Rd.

18. Funeral director: John J. Cowan & Son

Address: 961 Hollins St. Balto Md

19. Dec. 9 1940 (Date rec'd by registrar) C. Harry Klein Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1940 at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1939, to Dec 9 1940

and that I last saw h[illegible] alive on Dec 9, 1940

| Immediate cause of death | DURATION |
|---|---|
| Arteriosclerosis | 1929 |
| Due to: Myocardial degeneration | 1939 |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Maud M. Rees M.D.

M. D. or other

Address: Sykesville Md. Date signed 12-9-40

RECEIVED
DEC 14 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12548

Reg. Dist. No. 70

**1. PLACE OF DEATH:**
County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Mrs Joanna Orndorff

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | widow |

6 (b) Name of husband or wife: a. F. Orndorff

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 2, 1860

8. AGE: Years: 80 Months: 5 Days: 13 If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Geo C. Crapo
13. Birthplace: Md

MOTHER
14. Maiden name: Catherine Fleagle
15. Birthplace: Penna

16. Informant: Mrs Josephine Hull
Address: Taneytown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 15, 1940 (month) (day) (year)
Cemetery or crematory: St Joseph's
Location: Taneytown Md

18. Funeral director: Ott Bros & Son
Address: Taneytown Md.

19. Dec 17 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15 1940, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1940, to Dec 15 1940, and that I last saw her alive on Dec. 15 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Bronchopneumonia (type (unknown)) | 1 day |
| Due to: Fracture of femur from fall | 15 weeks |
| Due to: | |
| Other conditions: Chronic Myocarditis And Myocardial Degeneration (Include pregnancy within 3 months of death) | Sev. Yrs. |

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M.D. M. D. or other
Address: Taneytown, Md. Date signed 12/17/40

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 3 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12549

Reg. Dist. No. 76

**1. PLACE OF DEATH:**

County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 74 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Mary C. Read

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 21, 1854

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 5 | 19 | hrs. min. |

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Elias J. Read

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary M. Hutson

15. Birthplace: Maryland

16. Informant: Mrs. W. I. Dice

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/13/40 (month) (day) (year)

Cemetery or crematory: Pleasant Grove Cem.

Location: Sandyville, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 12/12/40 (Date rec'd by registrar) — Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10, 1940, at 5p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 26th 1940 to Dec. 10th 1940, and that I last saw h— alive on Dec. 10th 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Chronic myocarditis | several years |
| Due to: Senility | |
| Due to: Hemorrhage from bowel, appendicitis & hemorrhoids | 4 days |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings:

Ot operations:

Ot autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: C. B. Billingslea, M.D.
M. D. or coroner

Address: Westminster, Md. Date signed 12/11/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

12550

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1640)

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County Carroll

City or town Rural Nr Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Flohrville.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 yr.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Sykesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Flohrville
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** Paul Edgar Ripley

**3. (b) Social Security Number** —

4. Sex M.

5. Color or race W.

6. (a) Single, married, widowed, or divorced Widowed.

6 (b) Name of husband or wife Virginia Ripley.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 16. 1859

8. AGE: Years 81 Months 10 Days 20 If less than one day hrs. min.

9. Birthplace New Castle, Craig Co. Va.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Hillary Y Ripley
13. Birthplace Virginia

MOTHER
14. Maiden name Reakin
15. Birthplace Virginia

16. Informant H. H. Ripley

Address Sykesville Md (Flohrville)

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Dec. 7, 1940
(month) (day) (year)

Cemetery or crematory Oak Grove

Location Glenwood Md

18. Funeral director C. M. Waltz

Address Winfield Md

19. Dec. 5 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1940, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —

and that I last saw h — alive on — 19 —

Immediate cause of death Gunshot wound Head

Due to Suicide

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Suicide Date of 12/4/40

Where did injury occur? Flohrville (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Gunshot wound Injured at work? No

23. SIGNATURE Jas. T. Marsh. Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed 12/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (I) (T)

RECEIVED
JAN 4 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12551

Reg. Dist. No. 74

**1. PLACE OF DEATH:**

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 13 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 4 months, 13 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 34 Locust Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** WILLIAM HENRY SMITH

**3. (b) Social Security Number:** 216-03-7439

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | colored | single |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 14, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 6 | 24 | hrs. min. |

9. Birthplace: Easton, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER 12. Name: William Dobson

13. Birthplace: Maryland

MOTHER 14. Maiden name: Katherine Smith

15. Birthplace: Easton, Maryland

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 11, 1940 (month) (day) (year)

Cemetery or crematory: St. Luke

Location: Sykesville Md.

18. Funeral director: C. Harry Wells

Address: Sykesville Md.

19. Dec. 8 1940 (Date rec'd by registrar) Albert R. Swanhaus Deputy Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1940, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 26 1940, to Dec. 8 1940

and that I last saw him alive on December 8, 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Feb. 1940

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Superintendent

Address: Henryton, Maryland Date signed: 12/9/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12552

Reg. Dist. No. 74

**1. PLACE OF DEATH:**
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution? Same as above

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 Maderia Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** HERBERT STANTON

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | COLORED | SINGLE |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 30, 1922

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 18 | 8 | | hrs. min. |

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Delivery Boy

11. Industry or business: Unknown

FATHER
12. Name: Henry Love
13. Birthplace: Culpper, Virginia

MOTHER
14. Maiden name: Mary Stanton
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31 1940 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Brookland, Md
18. Funeral director: Elroy O Wilson
Address: 1000 Brantley Ave E.
19. Dec. 30 19 40 (Date rec'd by registrar) Albert R. Swindler Deputy Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 30th, 19 40 at 6:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9th. 19 40 to Dec. 30 19 40
and that I last saw him alive on December 30th. 19 40

| Immediate cause of death | DURATION |
|---|---|
| Tuberculous Menigitis | Dec. 23 1940 |
| Due to: Tuberculous pleurisy | June 30 1940 |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Maryland Date signed 12/30/40

RECEIVED
JAN 4 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12553

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos., 4 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 11 mos., 4 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2025 E. Preston St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME** Catherine Will

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: Edward Will
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 13, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 8 | 25 | ..... hrs. ..... min. |

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Laundress
11. Industry or business
FATHER 12. Name: Thomas Kilduff
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Mary ?
15. Birthplace: Baltimore, Md.
16. Informant: Edward Will
Address: 2025 E. Preston St., Baltimore, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 10, 1940 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.
18. Funeral director: H. W. Mears & Son
Address: Calvert & Madison Sts.
19. Dec 9 1940 (Date rec'd by registrar) C. Harry Weaver Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~Nov~~ Dec. 8, 1940 at 9:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4, 1940 to Dec. 8, 1940
and that I last saw h.. alive on Dec. 8, 1940

| Immediate cause of death | DURATION |
|---|---|
| Arteriosclerotic heart disease | Jan. 4, 1940 |
| Hypostatic bronchopneumonia | 8 days |
| Due to: | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Springfield State Hospital Date signed 12-9-40

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13 1940
BUREAU V.E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

12554

# CERTIFICATE OF DEATH

Reg. Dist. No. 76

**1. PLACE OF DEATH:**

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 280 East Green St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 280 East Green St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Mary Waunetta Yingling

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 22, 1856

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 10 | 9 | hrs. min. |

9. Birthplace: Westminster, Carroll, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: John Murray Yingling
13. Birthplace: Maryland

MOTHER
14. Maiden name: Louisa Warfield
15. Birthplace: Maryland

16. Informant: Samuel K. Yingling
Address: Westminster, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 1/3/41 (month) (day) (year)

Cemetery or crematory: Westminster

Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 1/2 (Date rec'd by registrar) 1941 G. Woodward Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31, 1940, at 9p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about 12/30 1935, to 12/31 1940, and that I last saw her alive on 12/31 1940.

Immediate cause of death: Chronic myocarditis — DURATION: 5 yrs.

Due to: Senility

Due to:

Other conditions: Edema of lungs — 1 day
(Include pregnancy within 3 months of death)

Major findings:

Dt operations:

Dt autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. L. Billingslea, M.D.
M. D. or other

Address: Westminster, Md. Date signed: 1/1/41

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

## CERTIFICATE OF DEATH

12555

Reg. Dist. No. 14

**1. PLACE OF DEATH:**
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs. 2 mo.
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 40 yrs. 2 mo.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 Lemmert Street
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Mary Frances Young

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | widowed. |

6.(b) Name of husband or wife Unknown
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Approximate 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | | | ..... hrs. ..... min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home

FATHER
12. Name Adam Young
13. Birthplace Germany

MOTHER
14. Maiden name Margaret Johnston
15. Birthplace No. Carolina

16. Informant Hospital Records
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19 1940 (month) (day) (year)
Cemetery or crematory Springfield Hosp.
Location Sykesville, Md.

18. Funeral director C. A. Heer
Address Sykesville, Md.

19. Dec. 15 1940 (Date rec'd by registrar) C. Harry Heer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1940, at 1.55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1940, to Dec. 14 1940 and that I last saw h.. alive on December 13 1940

| | DURATION |
|---|---|
| Immediate cause of death: Carbuncle of neck | 10 da. |
| Due to: Staphylococcus infection | |
| Due to: Diabetes | 1 yr. |
| Other conditions: Chronic Mental Disorder - Delusional Insanity | 40 yrs. |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hans M. Rees M. D.
M. D. or other
Address Sykesville Date signed 12-1-'40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 4 1941
BUREAU V. S.